City of Newport News
Employees' Retirement Fund
2400 Washington Avenue
Newport News, VA 23607
(757) 926-8546
(757) 926-3548 Fax

ENROLLMENT of Benefit Form
for Retirees

VISION SERVICE PLAN

SSN/EID _____ DOB _____MARITAL STATUS_____

NAME (LAST, FIRST, MI) _____

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

Type of Coverage:

____Employee ____Employee + 1 ____Family

Last Name (If Different) First Initial	Sex M/F	Birthdate Mo/Day/Yr
spouse **2**		
dependent **3**		
dependent **4**		
dependent **5**		
dependent **6**		

I AGREE TO HAVE DEDUCTIONS TAKEN OUT OF MY PENSION PAYROLL FOR THE NEXT 24 MONTHS AND WILL CONTINUE EACH YEAR THEREAFTER UNLESS CHANGED OR CANCELED DURING OPEN ENROLLMENT EVERY OTHER YEAR.

SIGNATURE_____DATE_____

- If you choose the plan for yourself, complete the form and check **"Employee".**
- If you choose to cover yourself and one family member such as a spouse or dependent child, check **"Employee +1"** and list the name of the spouse or dependent.
- If you choose to cover yourself and 2 or more family members, check **"Family"** and list all family members to be covered.
- Your unmarried dependent(s) may stay on your vision insurance through the end of the month in which he/she reaches 26.